

# The. California Smokers' Helpline: --- a case study

California Department of Health Services / Tobacco Control Section

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## **TOBACCO CONTROL SECTION**

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# INTRODUCTION

Activism around issues of tobacco control is on the rise in the United States. New laws restricting the advertising, vending, and use of tobacco are being passed, as well as new tobacco excise taxes. The tobacco industry has agreed to pay the states billions of dollars to settle their claims of past damages due to tobacco use. There is strong public support for proposals to earmark at least a portion of the settlement monies for tobacco control and cessation services.

In this environment, states are grappling with the issue of how to allocate new tobacco control resources so as to achieve the largest possible reduction in tobacco use among their populations. As a state which has already achieved a remarkable drop in adult smoking prevalence since the inception of its comprehensive Tobacco Control Program (from 26.7% in 1988 to 18.4% in 1998), California is the focus of great national attention. For this reason, the U.S. Centers for Disease Control and Prevention (CDC) have provided funding to enable the California Department of Health Services and its contractors to share their experience in tobacco control with other states. This case study was prepared as part of that endeavor.

It is intended for policy makers who are considering including cessation services in their

states' plans for tobacco control, as well as for public health professionals who need to know more about what is involved in running a successful statewide tobacco cessation service. It describes in some detail the California Smokers' Helpline, a key component of the California Tobacco Control Program's cessation efforts. It provides the essential background information and presents a rationale for the Helpline, shows how it supplements and compliments other state-funded tobacco programs, gives an overview of the services the Helpline provides, describes how it ensures the quality of those services, and gives evidence for their continued efficacy. It addresses promotional issues, as well as organizational and physical requirements, and offers suggestions for readers who wish to establish similar helplines elsewhere.

## 2 BACKGROUND

### Initial Investigation

Traditionally, high efficacy in the field of smoking treatment has been associated with intensive, face-to-face clinical programs rather than with low-intensity public health programs. Before there was data supporting its efficacy, telephone counseling for smoking cessation was regarded with some doubt, because it was difficult to see how a significant effect on an ingrained behavior such as smoking could be achieved just by talking over the telephone.

It was in this context in 1990 that researchers at the University of California, San Diego (UCSD) obtained funding from the California Department of Health Services to develop and test a telephone-based cessation service. The study not only demonstrated efficacy, but also showed that it was possible to bridge the clinical and public health approaches to smoking cessation. In other words, a helpline could combine the high efficacy of an intensive clinical program with the broad reach of a public health program.

The study, called the UCSD Smokers' Helpline, began in October 1990. Callers (N=3,030) were randomly assigned to receive one of three treatments:

- Self-help, consisting of a mailed packet of quitting materials
- Single counseling, including the self-help packet and one pre-quit counseling session
- Multiple counseling, which included the packet, the pre-quit session, and up to five follow-up counseling sessions

The counseling protocol was carefully designed to give the most useful assistance possible at the most appropriate times. Follow-up evaluation during the 13 months after subjects' first call to the Helpline yielded some important results. Subjects assigned to the counseling conditions were found to be more likely to make a serious quit attempt than self-help subjects (66.7% for single and 66.6% for

multiple counseling, versus 58.8% for self-help). More importantly, as shown in Figure 1, of those who did make a serious quit attempt, the subjects assigned to single counseling had a significantly higher rate of one-year continuous abstinence (19.8%) than those in the self-help group (14.7%). In turn, the subjects assigned to multiple counseling had a significantly higher abstinence rate (26.7%) than those in single counseling, and nearly double the rate of those in self-help. In other words, there was a clear dose-response relationship: the more intensive the service provided, the greater the quitting success. Moreover, the rate achieved by the multiple counseling group was comparable to rates associated with intensive, face-to-face clinical programs. Accordingly, on the basis of clear evidence demonstrating the feasibility and efficacy of telephone counseling for smoking cessation, in August 1992 the California Tobacco Control Program provided funding to establish the Helpline as a statewide program.

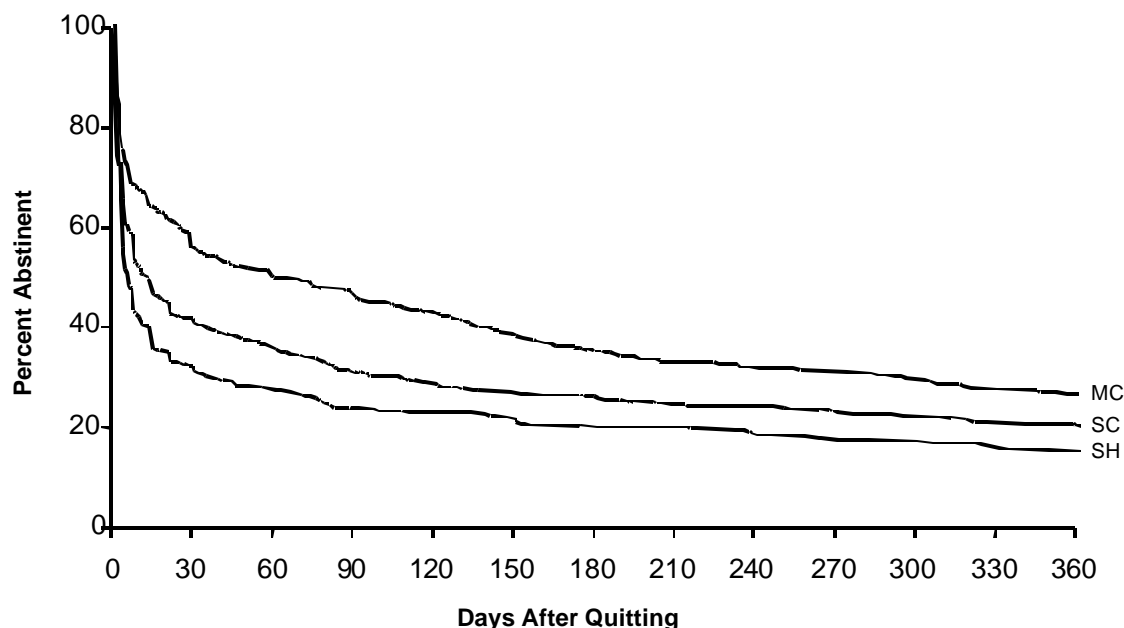
## The California Tobacco Control Program

The California Tobacco Control Program began in 1989 with the ambitious goal of reducing tobacco consumption by denormalizing its use across the state. As the program identified guidelines for making planning and funding decisions, four priority areas emerged:

- Protecting against exposure to environmental tobacco smoke
- Countering the influence of the tobacco industry
- Reducing youth access to tobacco
- Providing cessation services

The last of these areas proved to be problematic, because it was unclear whether providing cessation services to smokers was really helping change norms across the whole popu-

**Figure 1.** Relapse curves for self-help (SH), single counseling (SC), and multiple counseling (MC) groups. *Source:* Zhu, Stretch, Balabanis, et al. (1996)

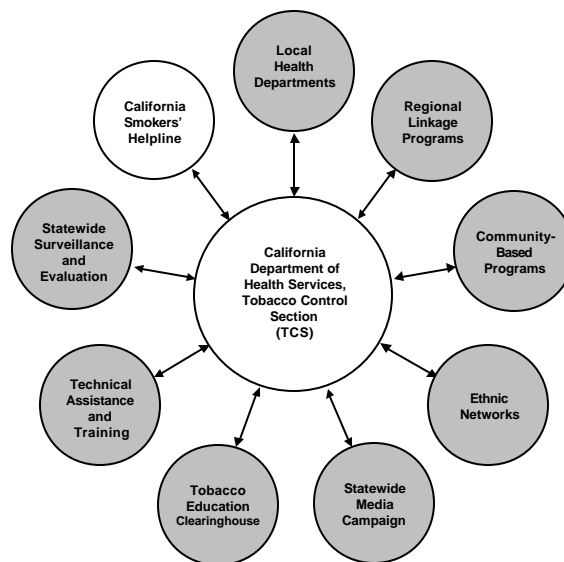


lation. It was thought that the program's resources would be better spent on changing the overall environment to *encourage* cessation rather than on providing direct cessation services. Accordingly, when the program revised its priorities in 1993, cessation was de-emphasized and the contracts of most cessation providers, outside of local health departments, were allowed to expire.

As a statewide, telephone-based resource with proven efficacy, however, the California Smokers' Helpline was retained. It is uniquely positioned to bring meaningful cessation assistance into places where few or no other resources exist, and well suited for individuals who are unable or unwilling to access local resources. Despite the state's focus on changing norms, and its reliance on environmental interventions to drive cessation, California's public health officials also recognize the need to provide services to the minority of tobacco users who want to quit but do not know how. Thus, the Helpline plays an important role in the state's comprehensive tobacco control program.

Figure 2 shows the Helpline in the context of the California's overall program. Funding for anti-tobacco activities is administered by the Tobacco Control Section (TCS) of the Department of Health Services. This body serves as the main link between program organizations. These include 61 local health departments each with its own comprehensive tobacco control program, 11 regional bodies which facilitate coordination between neighboring areas, an array of local community-based organizations, and four ethnic networks that coordinate activities affecting the state's ethnic minority communities. TCS also funds a statewide media campaign, a clearinghouse for tobacco-related materials, various technical assistance and training programs, and statewide surveillance and evaluation activities. The Helpline is seen as part of the program's statewide infrastructure and the core of its efforts to provide smoking cessation services. Readers who would like more detailed information about the overall program should refer to *A Model for Change: The California Experience in Tobacco Control* (1998), listed under the Suggestions for Further Reading.

**Figure 2.** The California Smokers' Helpline in the context of the overall California Tobacco Control Program





The rationale for a program such as the California Smokers' Helpline is compelling. Tobacco use is the most common preventable cause of death in California and around the world. Studies in multiple settings have clearly established that cessation counseling can increase the rate of quitting success. Moreover, among the range of effective cessation programs, a helpline is well suited to play a leading role in efforts to provide tobacco cessation assistance. The chief reason for this is its accessibility. Everyone in the state who has a telephone or who can get to one has access to the Helpline's free services. No other single cessation program can match the ability of its toll-free telephone lines to reach into every community in the state.

The Helpline provides assurance that local health officials always have somewhere to refer a smoker who needs help, and that no place in the state is ever without cessation assistance.

The Helpline improves accessibility in other ways, too. Many smokers are constrained by child care or transportation difficulties from participating in local programs. Others cannot afford the fees that some programs charge. Some do not want to wait for cessation classes

to form. None of these obstacles is an issue with the Helpline: free one-on-one help is available to anyone in the state, any time of the year, without leaving home.

### **The Benefits of a Centralized Service**

Not only is the Helpline easier for clients to access, it is easier for the state to promote. Instead of having to create many separate campaigns for a range of local programs, the California's statewide Media Campaign only



has one cessation service to promote (albeit in several languages). Also, ads broadcast in one county (e.g., San Francisco) that happen to spill over to other counties (e.g., Marin or Alameda) are not a problem, because Helpline services are available equally to callers from all counties. Promoting a single centralized service saves resources for other media needs, such as opposing youth access to tobacco or promoting smoke-free workplaces.

Equally as important, operating from a single centralized site permits a certain economy of scale. Smaller local programs would find it difficult to offer services continuously from 9 a.m. to 9 p.m. Monday through Friday and 9 a.m. to 1 p.m. Saturday, as the Helpline does. They would also have difficulty offering services in six languages. But the centralized nature of the Helpline makes it feasible to staff a year-round, multilingual program so that tobacco users across the state can obtain high-level cessation assistance in their preferred language. Moreover, quality assurance measures such as standardized training, rigorous clinical supervision, and continuing education are easier to maintain in a single setting.

## Other Considerations

There are additional considerations supporting the existence of the Helpline. An important one is that the semi-anonymity of telephone counseling seems to facilitate frank discussion. In group sessions, not only do participants have to wait their turn to speak, but many are too shy to speak openly about themselves. In contrast, speaking confidentially over the telephone to someone whom they will never see and who will never see them, clients tend to become candid very quickly. It is usually possible in a single session for counselor and client to develop a clear picture of the client's situation, enhance motivation and self-confidence, and create a workable plan for quitting.

Another strength of the Helpline in the context of public health interventions is the possibilities for proactivity that are inherent in a telephone-based service. In-person programs must rely on participants to keep showing up for sessions, but with a proactive calling procedure the Helpline is able to shift the burden for "attendance" more toward the program, thereby reducing attrition. The procedure can even be taken a step further by being used to recruit participants into a program. This is particularly useful with certain high-risk populations such as pregnant smokers who are not attending any other cessation programs.



## 4 DEVELOPMENT OF SERVICES OVER TIME

### **The Statewide Service: English and Spanish Counseling**

The initial helpline experiment had restricted its client base to English- and Spanish-speaking adult smokers in San Diego County. In August 1992, when the statewide Helpline began, the client base was expanded to include English- and Spanish-speaking smokers from the entire state. Because the multiple counseling protocol had been shown to be significantly more effective than the single counseling protocol, the Helpline adopted it as the norm, reserving the more abbreviated protocol for clients who presented with mental health issues outside of the scope of Helpline services.

#### **Spontaneous Quitters**

It soon became apparent that the statewide Tobacco Control Program was inducing many smokers to quit spontaneously and that many of them were calling for help after already starting their quit attempt. In response, in January 1993 the Helpline introduced a modified counseling protocol for spontaneous quitters. It allows counselors to provide immediate help with whatever concerns the client may have about the progress of the quit attempt, then catches him or her up on issues addressed in the pre-quit, quit day, and one-week sessions (as appropriate) before looking

ahead to future challenges. Of all smokers who have received counseling through the Helpline, about 11% were spontaneous quitters.

#### **Users of Nicotine Replacement Therapy**

Throughout the initial experiment, the use of nicotine replacement therapy (NRT) was not widespread. A small percentage of clients had either tried or were using nicotine gum, but nicotine patches were not approved by the FDA until 1991. So the majority of smokers who quit in the UCSD trial did so “cold turkey.” However, with FDA approval and major

advertising campaigns by the pharmaceutical companies, use of patches became more common among Helpline callers. It became even more common after Medi-Cal, the state agency administering federal Medicaid funds, designated the Helpline's telephone counseling program as an approved behavior modification program through participation in which Medi-Cal recipients could receive free nicotine gum or patches. As a result of these developments, NRT users began to comprise a large proportion of Helpline callers. In response, in July 1993 the Helpline modified its counseling protocol to provide complete information and follow-up on the proper use of the patches.

### **The Asian Helpline**

Soon after the start of the California Smokers' Helpline in San Diego, the Asian American Health Forum in San Francisco received training from Helpline staff and established a similar but smaller statewide program aimed at the non-English-speaking Asian and Pacific Islander (AAPI) population. The Asian Smokers' Helpline began serving callers in January 1993. Using translated protocols, the Asian Helpline provided intake services, materials, and counseling in Mandarin, Cantonese, Korean, Vietnamese, and Tagalog, the state's most dominate AAPI languages. However, due to staffing difficulties and sporadic call volume on the AAPI lines, the California Department of Health Services decided that it would be more efficient to combine the two programs. Consequently, in 1994 the Asian lines were transferred to the California Smokers' Helpline. The Tagalog line was discontinued due to low usage. The Helpline added bilingual Asian/English counselors to its staff, but without aggressive advertising found that the Asian lines were poorly utilized. In June 1998 the Media Campaign and its Asian

advertising agency contractor, Imada Wong, began airing a new and highly effective campaign to induce Asian-language speakers to call the Helpline (which will be described more fully in the section on methods of promotion). Since then, Asian smokers have actually been over-represented among Helpline callers. The Asian protocols are modified versions of the English protocols, the chief difference being that Asian-language smokers seem to prefer factual information to psychological counseling. With increased Asian call volume, developing and testing improved interventions for Asian-language smokers will be a focus of Helpline research in coming years.

### **The Teen Helpline**

The initial helpline experiment had excluded minors from the counseling program. Likewise, for the first few years of the statewide project minors could call and receive quitting materials but could not receive counseling. Due to the rising prevalence of smoking among adolescents, coupled with an almost universal lack of smoking cessation resources for them, many educators and tobacco control officials called upon the Helpline to lower its age limit for counseling. To do so, the Helpline had to overcome two barriers. It had to create a procedure for obtaining parental consent, which proved relatively simple since the great majority of underage callers were willing to involve their parents. A much larger barrier was the dearth of evidence for the efficacy of adolescent smoking cessation programs. In response, the Helpline obtained a grant from the National Institutes of Health to develop and test an innovative telephone counseling intervention for teen smokers, and in July 1997 began recruiting teen subjects into the study (N=1,400). The teen protocol has much in common with the adult protocol, but

pays close attention to developmental issues, especially as they relate to the process of habit formation, maintenance, and extinction. The study is nearing completion and the findings will be applied more generally if the protocol is shown to be effective.

To give teens an additional resource, the Helpline obtained funding through the Prop. 99-funded Tobacco Related Diseases Research Program (TRDRP) to develop a teen-oriented web site for smoking cessation, available at [www.nobutts.ucsd.edu](http://www.nobutts.ucsd.edu). Helpline staff often recommend that underage clients use the site in addition to the materials and counseling they receive. But with complete information about how to contact the Helpline, the site also serves to bring new teen clients into the phone-based program.

### **Helping Pregnant Smokers**

Another population that has generated much interest among public health officials is pregnant smokers. Since the establishment of the statewide Helpline, adult pregnant smokers were able to receive cessation counseling, but the protocol did not directly address issues unique to pregnant smokers, such as the high rate of relapse after delivery. Moreover, anecdotal evidence from counselors suggested that most of the pregnant women who called the Helpline fell into one of two groups. In one group were those who became highly motivated to quit as soon as they learned they were pregnant, and who seemed likely to quit even without help. In the other group were those who called only because their doctor told them to, and who seemed unlikely to quit even with a counselor's assistance. It was not clear whether either group was deriving a significant benefit from the program. So in March 1999,

the Helpline entered into a collaborative effort with the three major hospital systems in San Diego County to develop a specialized counseling protocol for pregnant smokers in which potential subjects are identified in the doctor's office and recruited into the program proactively by the Helpline. In July of that year the Helpline received funding from California's Prop. 99-funded TRDRP to develop and test a protocol especially for this population. As with the teen protocol, the findings may be applied more generally if the protocol's efficacy is established.

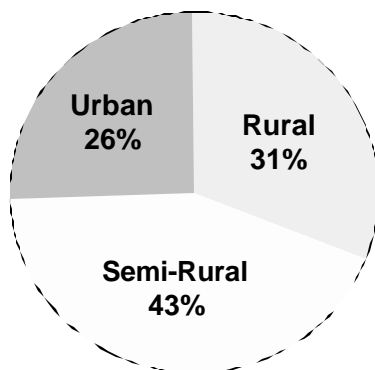
### **The Chew Line**

Since the start of the statewide Helpline, counseling was available to smokeless tobacco users who called any of the smoking lines. However, with increased attention being paid to the prevalence of smokeless tobacco, especially in rural areas of the state, in July 1997 a separate "Chew Line" was added to the Helpline's roster of toll-free numbers. The counseling protocol used with chewers is a modified version of the protocol used with smokers. Follow-up surveys with chewers who have received Helpline counseling show preliminary rates of success that are comparable to those of adult smokers, as well as a high level of satisfaction with the service they received. A rigorous evaluation to ascertain the Helpline's efficacy in working with this population remains to be done. In coming years the Helpline will seek research funding to conduct such a trial.

In contrast to the main smoking lines, which are utilized by more women than men (55.0% are female), the Chew Line is used almost entirely by males (96.1%). And, as Figure 3 illustrates, the majority of callers are from rural

or semi-rural areas of the state. Whether for chew or for cigarettes, a service such as the Helpline is especially valuable in remote or rural areas where it is harder to assemble groups.

**Figure 3.** Percentages of Helpline clients receiving counseling for chewing tobacco cessation from rural, semi-rural, and urban counties

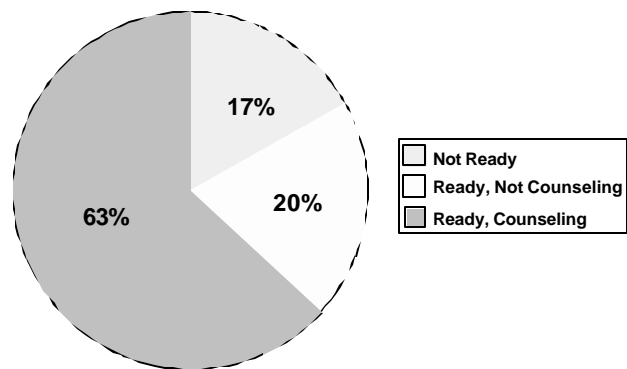


## New Directions

The Helpline is currently developing improved interventions for other groups. One group consists of smokers who report that they are not ready to quit when they first call. They comprise a small but significant percentage of all callers. The Helpline has investigated a brief counseling intervention designed to move them closer to quitting, that can be used in addition to the motivational materials they

receive. Another group consists of callers who say they are ready to quit smoking but want to try it on their own. The Helpline is developing a low-cost intervention for them, consisting of computer-generated tailored mailings in addition to the standard “quit kit” sent to all who are ready to quit.

**Figure 4.** Percentages of Helpline callers who were current smokers and (1) not ready to quit within a week, (2) ready to quit but wanting self-help materials only, and (3) ready to quit and opting for counseling



To show the proportions of callers who belong to these groups, Figure 4 gives a breakdown of all smokers who have called the Helpline. It divides them into three categories: (1) those who are not ready to quit smoking within a week of intake, (2) those who are ready but who request self-help materials only, and (3) those who are ready and opt for counseling.



## CESSATION METHODOLOGIES

To help people quit using tobacco, the Helpline takes a stepped-care approach to providing services, in which each caller determines the services he or she will receive. These services range from low-intensity interventions with almost all callers to high-intensity interventions with subsets of callers.

### **Referral to Local Programs**

The least intensive of the Helpline's interventions is referral to local programs. The program works with tobacco control officials in all of the 61 local health departments across the state to maintain up-to-date listings of all the legitimate tobacco cessation services in each county. Legitimacy is determined at the local level; most of the county health departments choose to list traditional cessation classes, group support, individual counseling, and any programs provided by the major voluntary agencies, but are somewhat less likely to list alternative modalities such as hypnosis and acupuncture. The listings include the name, address, and telephone number of each program along with a brief description of services provided, languages served, and cost (if any). Given the fact that programs often come and go, the Helpline updates these lists about twice a year to make sure the information is current. All callers receive a

copy of the list for their area in the packet of materials that is sent out within 24 hours after they call the Helpline.

### **Psychoeducational Materials**

The psychoeducational materials placed in the packets that English- and Spanish-speaking adult callers receive depend on their self-reported readiness to quit. Clients who say they are not ready to quit within a week receive a Helpline-produced booklet designed to help them decide. It provides important facts about smoking, has them weigh their reasons to keep smoking against their reasons to quit, gives them useful suggestions for facing the prospect of quitting, and in general helps boost their self-efficacy. The goal of the booklet is simply to move them closer to quitting. They are encouraged to call back when they feel ready to take the next step.

Callers who report that they are ready to quit

within a week (including previously unready clients who are calling a second time) receive other Helpline-produced booklets designed to help them quit and stay quit. The booklets walk them through the process of planning and carrying out a successful quit attempt. They help clients identify the situations that will make them want to smoke, and plan strategies for getting through them without smoking. They explain and normalize withdrawal symptoms, help clients deal with slips and relapse, and give suggestions for keeping their motivation up and staying smoke-free for life. They are designed to be used as self-help materials, not simply as an adjunct to counseling, because many callers request materials and want to quit on their own. Certainly, from the standpoint of maximizing precious public health resources, it is desirable to be able to accommodate such clients in this way; it means that more resources are available for the clients who feel that they need more intensive help.

Asian-language cessation materials in general are scarce, and the Helpline has not had funding to develop its own. Therefore, Asian-language callers receive the best cessation booklets currently available on the market. These booklets cover the main issues addressed in the English and Spanish booklets, but in a more condensed format.

Teen callers, regardless of their self-reported readiness to quit, receive two booklets produced by the Helpline that cover both the decision to quit and the actual quitting process. They are designed to be not only developmentally appropriate but stylistically appealing to today's teens. The language, graphics, pacing, and overall style of the booklets are best described as "in-your-face" and "edgy." They received high marks when tested on teen focus groups. Figure 5 shows the front cover of one of these two booklets.

**Figure 5.** Front cover illustration of ButtsOut Issue#1, a Helpline-produced booklet designed to help motivate teen smokers to quit



### Tailored Mailings

Another relatively low-intensity modality for providing cessation assistance is currently under development. Computer-generated mailings that are tailored according to information gathered during intake will be sent to those who do not choose to receive counseling. The mailings are intended, in as unobtrusive a way as possible, to keep cessation on the client's mind as a priority, and to give uniquely useful information about successfully quitting. They include letters comprised of stock paragraphs corresponding to self-reported data, such as daily number of cigarettes smoked, time between waking and smoking, number of quit attempts in the last five years, longest quit attempt, etc. The letters also invite clients to

call back for more assistance, either in the form of counseling or more materials. Follow-up letters are designed to help keep them engaged in the process of quitting.

## **Counseling**

By far the most intensive methodology employed by the Helpline to help people quit using tobacco is one-on-one telephone counseling. What follows is a discussion of the procedures for enrolling clients into counseling, some unique features of Helpline counseling, the theoretical basis for it, and an overview of the protocol itself.

### *Logistics*

In order to extend its resources as far as possible, the Helpline divides the intake and counseling functions and employs a number of staff who perform intake only. An intake worker, or “screener,” explains the various services which the client may receive, and records his or her choices. For most clients who choose counseling, the screener explains that they will receive a “quit kit” in the mail within a few days, and that in the quit kit there will be a second toll-free number, to be used to call back for counseling. This procedure gives clients a chance to look over the materials before beginning counseling. It also provides a way to ensure that the Helpline’s counseling resources are fully utilized yet not overwhelmed, despite fluctuations in the weekly call volume.

Achieving this balance amid the ups and downs in the call volume is possible due to the fact that not all clients immediately follow the instructions to call back. The many clients

(about a third) who do call back are assigned to a counselor, after which the counselor makes arrangements for the first and all subsequent sessions directly with each client. Of the even greater number of clients who choose counseling but who fail to call back, either because they decide to quit on their own or because they grow more ambivalent about quitting, the Helpline proactively calls on a randomized basis as many as time and funding allow. So there are three main ways in which clients are assigned for counseling:

- Urgent cases are assigned after intake.
- Those who are instructed to call back and who do so are assigned after the second call.
- Many of those who do not call back (either because they have changed their mind or because they have not gotten around to it yet) are assigned for proactive contact by a counselor.

For a more detailed discussion of the scientific and managerial implications of these procedures, please see Zhu (1999), listed under Suggestions for Further Reading.

### *Unique Features of Helpline Counseling*

Several important features distinguish the counseling provided by the California Smokers' Helpline, as compared to other cessation programs. First, in most cases the counseling sessions are initiated proactively by the counselor. Although each client has to make the first move by calling the Helpline, and although some of them are required to call back for counseling after they have received their quitting materials, as outlined above, all subsequent sessions are initiated by the



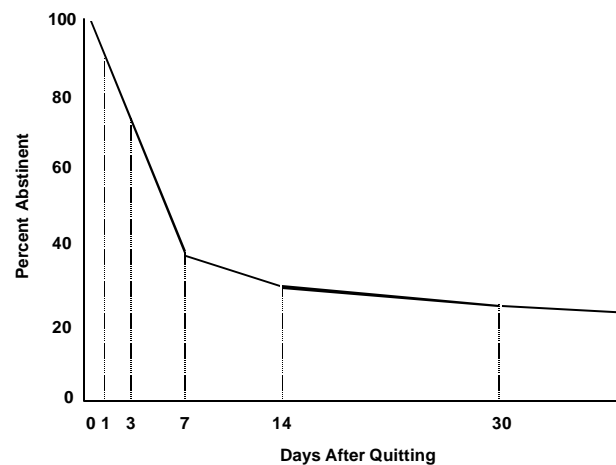
counselor. The reasons for this approach are to communicate support as well as a certain level of accountability, to help resolve the client's ambivalence, and to encourage the client to move forward. Naturally, it also reduces attrition.

Another feature of Helpline counseling is that it follows a structured protocol. Use of the protocol helps the counselor to be comprehensive in his or her attention to the relevant issues, but also to be brief and focused. The protocol outlines the minimum acceptable content for each session and guides the flow of the discussion. It is sensitive to the different phases of cessation, prompting the counselor to raise the issues that are most likely to be of concern at each phase. It is not intended as a complete script, however. The counselor adds freely to the protocol in response to each client's unique concerns; the protocol can be viewed, in effect, as a springboard into whatever issues are appropriate for the individual client at each point in his or her progress.

A final important feature of Helpline counseling relates to its manner of scheduling sessions. The counselor spends one session with each client helping him or her prepare to quit. Then if follow-up sessions are provided, they are scheduled according to the probability of relapse. In other words, the likelier the client is to relapse (based on population statistics), the more frequent the sessions are. The counselor typically provides sessions within 24 hours of quitting, again two days later, then again three or four days later. Thereafter the intervals between calls keep getting longer. Relapse-sensitive scheduling, as this method is called, ensures that the counselor's time for follow-up is allocated at the times when it is most likely to benefit the client: in the first week of quitting, when, unaided, over 60% of

smokers relapse. As illustrated in Figure 6, this approach has the effect of "propping up" the relapse curve, resulting in significantly higher long-term abstinence among those who receive follow-up counseling. For more discussion of relapse-sensitive scheduling, please refer to Zhu & Pierce (1995), listed under Suggestions for Further Reading.

**Figure 6.** An abstinence curve for smoking cessation, showing the Helpline's points of intervention scheduled according to the probability of relapse at 1, 3, 7, 14, and 30 days after the start of the quit attempt. *Source:* Zhu and Pierce (1995)



### *Theoretical Basis*

The content of Helpline counseling is based on social learning theory, especially with respect to the theory's emphasis on the individual's capacity to self-regulate and the importance of self-efficacy in the process of effecting behavior change. In practice, Helpline counseling follows a combination of the principles of motivational interviewing with regard to inducing behavior change, and the cognitive-behavioral approach to treating substance

abuse. Using motivational interviewing, the counselor forges a collaborative relationship with the client through which the client's motivation to change is enhanced. With the cognitive-behavioral approach, the counselor works to restructure the client's beliefs about smoking and cessation and encourages the client to develop and use effective coping strategies. The role of the counselor, then, is to promote the client's motivation for change and to help him or her develop competence in self-regulation. These principles are embodied in the protocol and are thoroughly addressed in training and supervision.

### *The Protocol*

The protocol covers two phases of quitting: preparation and maintenance. The preparation phase is addressed in a single session. It is the most comprehensive and, at about 45 minutes, also the longest. In this session, the counselor assesses the client's unique situation, including his or her smoking and quitting history, current smoking levels and patterns, and environmental factors. The client's personal motivation to quit is explored and enhanced. Because confidence tends to be low among those who seek help to quit, self-efficacy is addressed. The counselor helps identify the situations which are going to be the most difficult to handle without smoking, and also helps develop strategies for getting through them.

Finally, the counselor asks the client to commit to a quit date and, in most cases, arranges a time to call back on that date to provide support.

The maintenance phase is addressed in follow-up sessions which begin on or soon after the client's quit day. The focus of these sessions is avoiding relapse. The counselor addresses any withdrawal symptoms the client may be experiencing and attempts to normalize them. Together they evaluate the quitting plan by discussing the difficult situations that have arisen, whether the planned coping strategies were used in those situations, and, if so, whether they were effective. They discuss slips and relapses, the counselor endeavoring to decatastrophize these events if they occurred, and revise the plan as needed. At each contact, self-efficacy and motivation are revisited. And gradually, the client is encouraged to develop the self-image of a nonsmoker (as opposed to that of a smoker who simply abstains). The Helpline considers such a self-image to be the most effective device the client can use to protect against relapse in the long term.

Readers who wish to read about the Helpline's counseling protocols in more detail should refer to Zhu, Tedeschi, Anderson, and Pierce (1996), listed under Suggestions for Further Reading.



## HIRING AND TRAINING OF COUNSELORS

The Helpline is fortunate to be located in San Diego, an area that has several local graduate programs in psychology, counseling, and social work, and a relative abundance of mental health professionals. Even so, when hiring new counselors the Helpline mounts an aggressive recruitment campaign. Because services are offered in six languages, many qualified bilingual staff are required. There is also a TDD line for the hearing impaired, and staff are needed who have some familiarity with the deaf community.

The range in education among new counselors is from the bachelor's to the doctoral level. Professional experience also varies. Regardless of background, all new counselors participate in an intensive training course which is facilitated by the clinical director and that prepares them to provide effective telephone counseling for tobacco cessation.

One of the key themes of the training is research. Counselors are central players in Helpline studies, so they receive training on fundamental concepts of experimental research, such as the importance of conducting randomized controlled trials to determine the efficacy of new interventions. They survey the relevant literature on smoking cessation, particularly with respect to telephone counseling, and discuss the scientist-practitioner model as it relates to public health research.

Another key theme of training is the psychology of smoking and of the smoking cessation process. Counselors learn about the process of habit formation, maintenance, and extinction; the idea of habit versus that of addiction; current models of addiction; the nature of nicotine addiction; relapse and how it is processed psychologically; the motivational structure of smoking and smoking cessation; and the role of self-image in smoking initiation, maintenance, and cessation.

The training also covers general principles of counseling applicable to any work in behavior modification, for example, the difference between counseling and psychotherapy. Many Helpline counselors are qualified psychotherapists, but they do not practice it because psychotherapy is outside of the Helpline's scope of work. The historical context of

counseling is discussed, as well as some of the traditional theoretical approaches. Trainers distinguish between counseling theory and counseling technique and encourage staff to work from a defined theory base while utilizing an eclectic repertoire of techniques.

Counselors explore the psychological bases for change, counseling strategies to assist change, and counseling style vis-à-vis clients' readiness to change. Counselors must be able to adapt their styles to different degrees of client readiness, as well as to different personal and social characteristics. The training covers basic concepts of motivational interviewing, cognitive behavioral counseling, and self-regulation theory. Primary counseling skills, concepts, and techniques that can be used to help clients change are also discussed.

Many other special counseling topics are covered, such as the abstinence violation effect (AVE), positive expectancy, alcohol and smoking, coping with highly emotional situations, psychiatric diagnoses and smoking, pharmacological treatments including nicotine replacement therapy (NRT) and Zyban, smoke-

less tobacco, dealing with client resistance, stress management, referral procedures, the confidentiality of client information, risk assessment and emergency procedures. (All telephone staff, not just counselors, are trained to respond to crisis situations such as when a client threatens suicide.) The counselors are also trained in the use of the intake and counseling protocols. With regard to case management, they learn ways of maximizing productivity, while minimizing burnout. Standard procedures for managing client files are also covered.

The training is hands-on, with new staff seeing demonstrations and doing exercises in groups and pairs. They shadow veteran counselors in their work areas and role-play with them over the telephone to gain experience and confidence. Before they speak with any real clients, they must pass a written comprehensive learning assessment and role-play as a counselor with the clinical director or a senior counselor playing the part of a client. Thereafter, counselors receive continuing education in the form of staff presentations, guest speakers, workshops, and seminars.



## QUALITY ASSURANCE

Counseling quality is maintained and strengthened in a number of ways including training, supervision, a structured protocol, evaluation and peer feedback.

The responsibility of overseeing the work of counselors is split between two supervisors. The clinical director, a California-licensed psychologist aided by two senior counselors, supervises the content and delivery of sessions. Beyond facilitating training and continuing education, the clinical director monitors individual calls and debriefs sessions with counselors, working with each counselor to build his or her clinical strengths in the areas of behavior modification and addictions treatment. Meanwhile, the counseling administrator oversees case management, meeting regularly with individual counselors to review their performance statistics such as the number and percentage of assigned clients who received counseling, the number of follow-up sessions per client, the average length of sessions, the number of attempts to reach clients, etc. Attention to both these areas from the two supervisors helps ensure a consistently high level of performance not only with regard to clinical rigor but also with respect to timeliness and efficiency.

The structured counseling protocol, which all new counselors are trained to use, is another powerful mechanism for quality assurance. As discussed in the section on Cessation Method-

ologies, the protocol is the backbone of the program's clinical content. It serves as a consistent reminder to each counselor of the clinical issues considered to have the most bearing on quitting success.

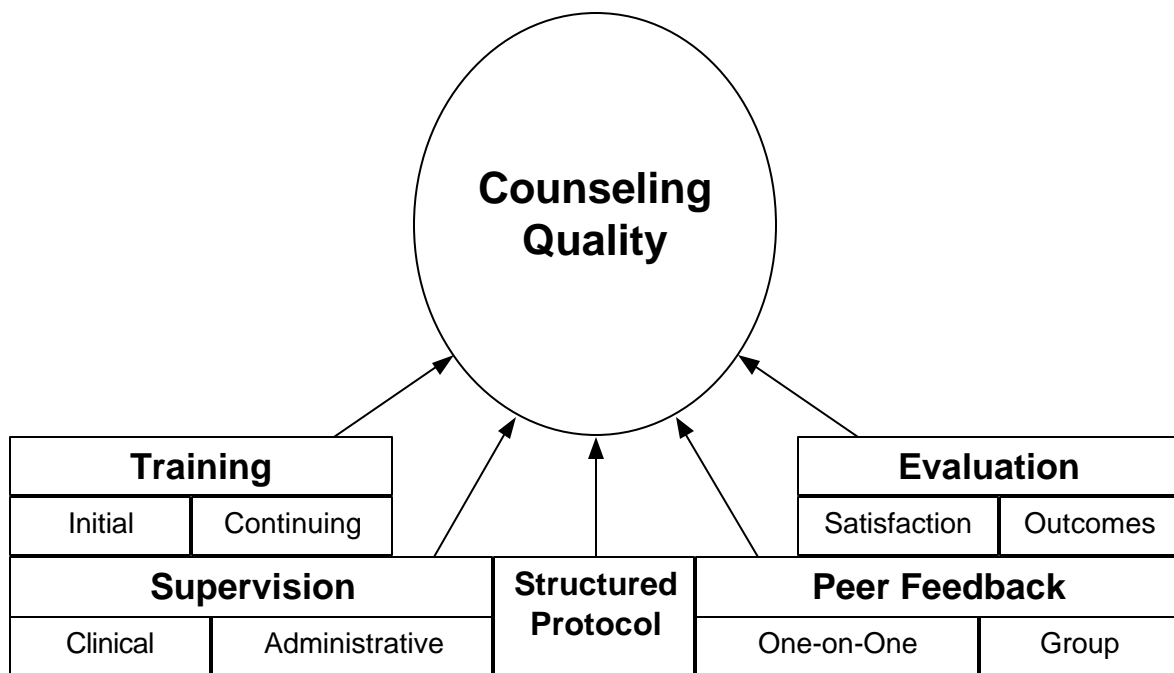
In addition to their individual efforts to provide service of a high quality, counselors are encouraged to support counseling quality by giving and receiving peer feedback. Because counselors can overhear each other speaking to clients, they are in a good position to help ensure the accuracy of information provided, as well as to encourage adherence to the Helpline's basic therapeutic approach, on an informal basis. They also participate in weekly group supervision meetings, where giving and receiving peer feedback is more formalized. In these meetings, challenging clinical issues are raised and individual case studies are discussed. In facilitating such meetings, the clinical director or a senior counselor draws upon the diverse talents of the individuals present to build quality in the group. Whether formal or informal, peer feedback extends the ability of the Helpline to ensure the quality of the service it offers.

Further feedback comes in the form of data

from the Helpline's evaluation department. In follow-up surveys with randomly selected clients, the evaluators collect objective behavioral data such as smoking status as well as more subjective satisfaction data. Clients' assessments of the quality of the service they received are shared anonymously with the counselors who worked with them, including answers to specific questions such as whether the counselor was a good listener, nonjudg-

mental, supportive, knowledgeable in issues relating to quitting, and reliable in keeping appointments. Aggregate outcome data from clients participating in experimental trials are also used to evaluate the efficacy of the various protocols and to refine the service on a programmatic level. Some of the results obtained through rigorous program evaluation are described in more detail in the next section.

**Figure 7.** Elements supporting counseling quality at the California Smokers' Helpline



## EVALUATION— EVIDENCE OF CONTINUING EFFICACY

When the Helpline became a statewide service in 1992, it had the advantage of a counseling protocol that had been proven effective in an experimental study. There was a legitimate concern, however, whether the protocol would still achieve a high quit rate after being translated from a research to a service setting.

A service project generally has to accommodate clients' requests more than a research project does, and does not screen participants out. Moreover, it often happens that quality assurance efforts are slackened once the research is done. Aware of this tendency and

committed to retaining its efficacy in the new service project, the Helpline increased its efforts to ensure quality. In fact, some of the quality assurance measures described in the previous section began during the statewide project, not during the experimental trial.

**Table 1.** A comparison of quitting attempts and 12-month abstinence by smokers in two Helpline trials

Trial	Quit attempt rate (quit for 24 hrs.) %	12-month abstinence rate for those who attempted to quit %
UCSD Smokers' Helpline (N=3,030)		
Self-help	58.8	14.7
Multiple Counseling	66.6	26.7
California Smokers' Helpline (N=3,328)		
Self-help	48.4	18.8
Multiple Counseling	63.0	25.9

As part of quality assurance, the Helpline developed an innovative evaluation design that was embedded in the service. The design allowed a second randomized trial of the Helpline counseling protocol to determine whether it was still effective in a service setting. Readers who would like to read further about the design of this study are referred to Zhu (1999), listed under Suggestions for Further Reading.

Table 1 presents the evaluation data obtained from the second trial (N=3,328), along with data from the earlier UCSD Smokers' Helpline

as a comparison. The percentage of smokers in each group who made a serious quit attempt (i.e. lasting 24 hours or more) is presented, as well as the percentage of those who, having made an attempt, went on to achieve 12-month continuous abstinence from smoking. In the second trial as in the first, the counseling group had both a significantly higher rate of quit attempts than the self-help group and a significantly higher 12-month abstinence rate. The replicated results give confidence that in fact the statewide Helpline has continued to offer effective help for smokers who want to quit.



## METHODS OF PROMOTION

### The Statewide Media Campaign

The Media Campaign is a crucial element of the California Tobacco Control Program, and its advertisements of the Helpline, in turn, are an important part of the campaign. Helpline ads run on television, radio, billboards, bus signs, and in local newspapers, and are effective in getting smokers and nonsmokers alike to think and talk about smoking. They contribute to the program's overall goal of denormalizing tobacco use; correspondingly, they help to normalize *quitting*, which becomes easier for individual tobacco users to consider, since quitting comes to be seen as a broader social movement.

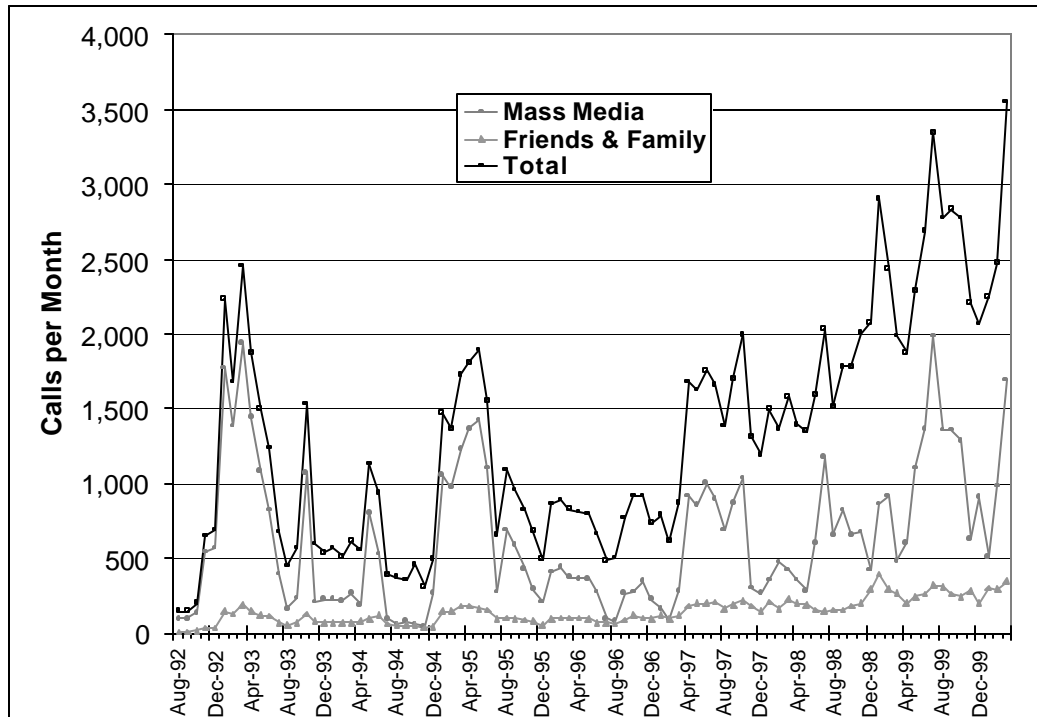
Moreover, it is likely that the ads induce many smokers to quit on their own without even calling, by giving them the assurance that they can get help if it turns out that they need it. And they help to soften the message of the program by offering not just information about the negative effects of smoking, but also a helping hand for those who feel they need it to quit. Finally, the ads build awareness of Helpline services among many individuals who interact with tobacco users, from health care professionals and educators to friends and family members. With regard to the latter, it is useful to note that when media advertising of the Helpline increases, so does referral by friends and family. This is illustrated in

Figure 8, which shows the total monthly call volume, the volume generated by the mass media, and the volume generated by family and friends. The correlation between the latter two shows that the ads work both directly and indirectly.

#### *What Makes Ads Effective?*

Of course, the immediate goal of Helpline ads is to prompt tobacco users to call, and several factors bear upon their effectiveness in achieving this goal. Naturally, the resources spent producing the ads are key, but just as crucial is the "impactfulness" of the ads. The ads may be comical or serious, uplifting or upsetting,

**Figure 8.** Number of callers to the California Smokers' Helpline referred each month by (1) mass media advertising, (2) friends and family members, and (3) all sources combined



but they must have impact. Also important is the number of times the ads are aired, as marketers understand that ads usually must be repeated several times before they begin to affect behavior. Two factors related to the telephone number itself are important: how easy it is to remember, and how prominently it figures in the ad. The Helpline is fortunate to have 1-800-NO-BUTTS as its most frequently advertised number, which is easy to remember. With regard to the prominence of the number, the length of time it is on the screen during a television ad, the number of times it is repeated in a radio ad, and the size and clarity of the number in a billboard or print ad all affect how many calls the ad produces.

Another key factor is the cultural and linguistic appropriateness of the ads for their target population. The Helpline receives a large number of calls from ethnic minority smokers only when ad campaigns carefully targeted to these populations are aired. It should be noted that careful targeting may mean changing not just the ethnicity and language of the actors, but also the portrayal of the program itself. Most Asian-language smokers, to give a specific example, will not call a “counseling” program (perceived as a mental health service), but many will call a “help” line (perceived as an information and advisement service). Ads must be careful to accommodate such cultural differences.

Finally, one of the most important factors determining the ability of Helpline ads to get smokers to call is the amount of tie-in to related messages from the rest of the Tobacco Control Program, including both local programs and the statewide campaign. Helpline ads are reinforced by the fact that smokers will likely have heard several anti-tobacco messages from a variety of sources before they see an ad promoting the Helpline. The other messages increase ambivalence about smoking so that when they see a Helpline ad, they are more willing to call.

### *Successful Themes*

Helpline ads developed by the campaign have dealt with several impactful themes, most of which also appear in non-Helpline ads. Not surprisingly, many of them have to do with health concerns. One of the most frequently recurring themes is the danger of secondhand smoke, as seen from various personal angles, primarily its negative impact on the smoker's family. These ads directly support the goal of

denormalizing tobacco use by reducing exposure to secondhand smoke. Other ads address the smoker's own health, to great effect. One famous ad, shown in Figure 9, features a simple testimonial from a woman in her forties named Debi, who began smoking when she was 13 years old. She eventually developed cancer of the larynx and had to have her voicebox removed. The ad serves as a powerful reminder of the health hazards of smoking.

Ads also address other themes that support cessation. In the "Voicebox" ad just mentioned, for instance, Debi continues to smoke despite the fact that she must do so through a stoma at the base of her neck. Besides the health hazards of smoking, she raises two other potent themes: the insidiously addictive nature of nicotine and the deceitfulness of the tobacco industry, which until recently has insisted—even under oath in Congressional hearings—that nicotine is not addictive. Closely related is the theme of wanting to be free of control. This theme is central to some highly effective comic ads developed by Massachusetts' tobacco control program and aired in California. These ads capitalize on the idea of the "smoker's epiphany," the moment in a smoker's life when he or she realizes it's finally time to quit. One such ad features a nicely dressed woman on a dinner date who sneaks a smoke in the restroom, only to get her foot stuck in the toilet trying in vain to keep the smoke-detector from triggering the fire-sprinklers. The furtiveness of her sneaking away for a cigarette, and the ignominy of the consequences, bring up the very salient theme of the social undesirability of smoking. Ads conveying these ideas seem to sharpen the desire to quit.

Finally, some ads simply give encouragement and build self-efficacy. They convey the idea that those who have quit without success in the

**Figure 9.** "Debi," from the California Media Campaign-produced television ad "Voicebox"



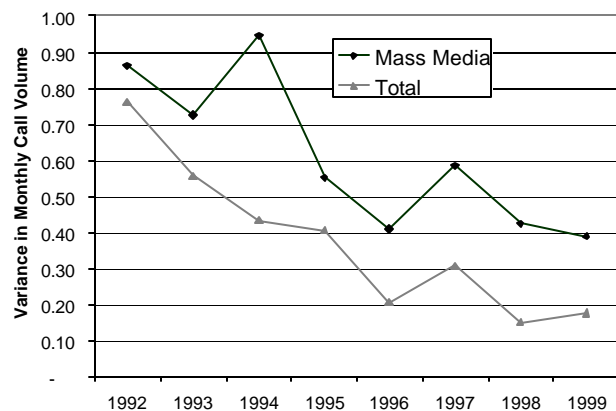
past should keep trying—because quitting takes practice—and the idea that quitting is easier with help, which they will receive if they call. No single theme holds the key to promoting Helpline services. In fact, the variety of approaches seems to keep the central idea fresh: that help is available for those who need and want it.

### Media Lessons Learned

Over the years the Media Campaign and the Helpline have developed a close working relationship, learning several important lessons along the way. The first is that promoting the Helpline is unlike any other public health promotion, due to the fact that the level of Helpline staffing must correspond to the intensity and net effectiveness of the campaign. Exceptionally large promotions resulting in very high call volume could impair the Helpline staff's ability to serve all callers. Correspondingly, the low volume occurring between promotions could lead to the underutilization of Helpline staff. What is needed, then, is a relatively constant level of promotion so that all calls can be handled and all staff are fully utilized. However, marketers understand that constant promotions soon lose their ability to command attention. The solution that the Media Campaign and the Helpline struck upon is to let the ads "travel" around the state, blitzing one or two regions at a time and then moving on to another area. In this way the campaign never grows stale in any one location, and the Helpline enjoys a more manageable overall call volume. The media "buy" for ads with the Helpline number is spread out both geographically and with respect to time, so that there is almost always some sort of Helpline promotion occurring somewhere in

the state. There still are large fluctuations in the call volume due mainly to changes in mass media, but relative to total call volume, the variability has decreased with time. This is shown in Figure 10, which tracks the coefficient of variation in the monthly call volume, year by year. In both the number of calls generated by media and the total number of calls, the monthly variability has decreased.

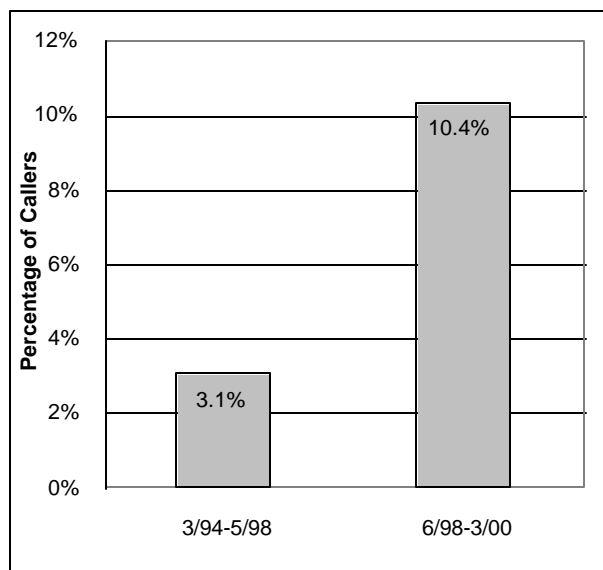
**Figure 10.** Variance in the Helpline's monthly call volume generated by (1) mass media and (2) all sources combined



Another lesson learned is the value of close cooperation on problematic promotional issues. A situation in which there was a particularly big benefit from this kind of cooperation occurred before a recent campaign to promote the Asian line. Disappointed by lackluster results from previous efforts, the campaign asked its Asian advertising contractor, Imada Wong Communications Group, to meet directly with the Helpline staff members who provide service for Asian-language clients. The counselors reported and focus groups confirmed that Asian-language callers seemed to have different expectations from

those of their English- and Spanish-speaking counterparts. A much higher percentage of Asian callers were nonsmokers calling on behalf of someone else: usually a woman calling for her husband or son. And, as mentioned earlier, the smokers who called were more likely to request materials or factual information, and less likely to ask for psychologically oriented counseling, which is a very popular component of the English and Spanish lines. With this input, the Media Campaign and Imada Wong created a new promotion more closely addressing the expectations of this population, and Asian call volume soared, as shown in Figure 11.

**Figure 11.** Percentage of all Helpline callers who were of AAPI background, before and after the start of the Imada Wong campaign



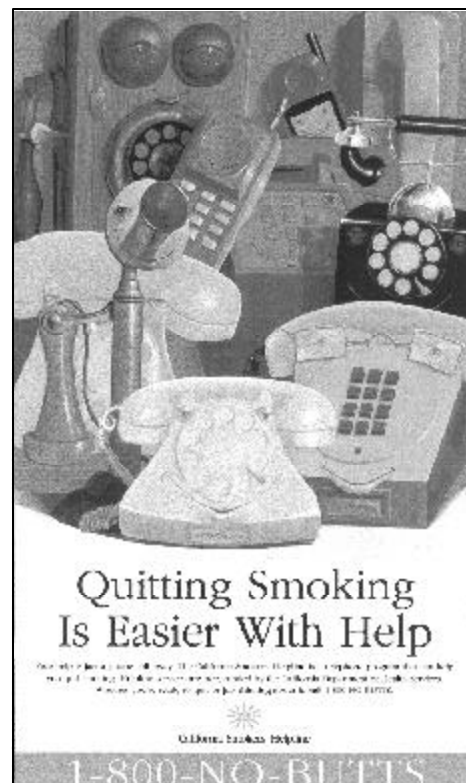
## Reaching Out to Referrers

For the first few years after it was established in 1992, the Helpline was highly dependent on media advertising. Most people who called at that time were either responding to an ad, or were referred by someone else who had seen or heard one. With time, however, the Helpline

gradually became a trusted referral resource for healthcare providers, local health departments—especially rural ones with few local cessation resources—and others. To build upon the expanding network of referral sources, and to complement the Media Campaign’s emphasis on direct outreach to smokers, in November 1996 the Helpline added a small outreach component of its own.

Its mission is to increase awareness of Helpline services among all who are in a position to refer tobacco users, and it has three major areas of focus. First, it reinforces the efforts of health care providers who refer their patients, by sending them thank you cards (without revealing their patients’ names). Most physicians cannot take the time to provide cessation

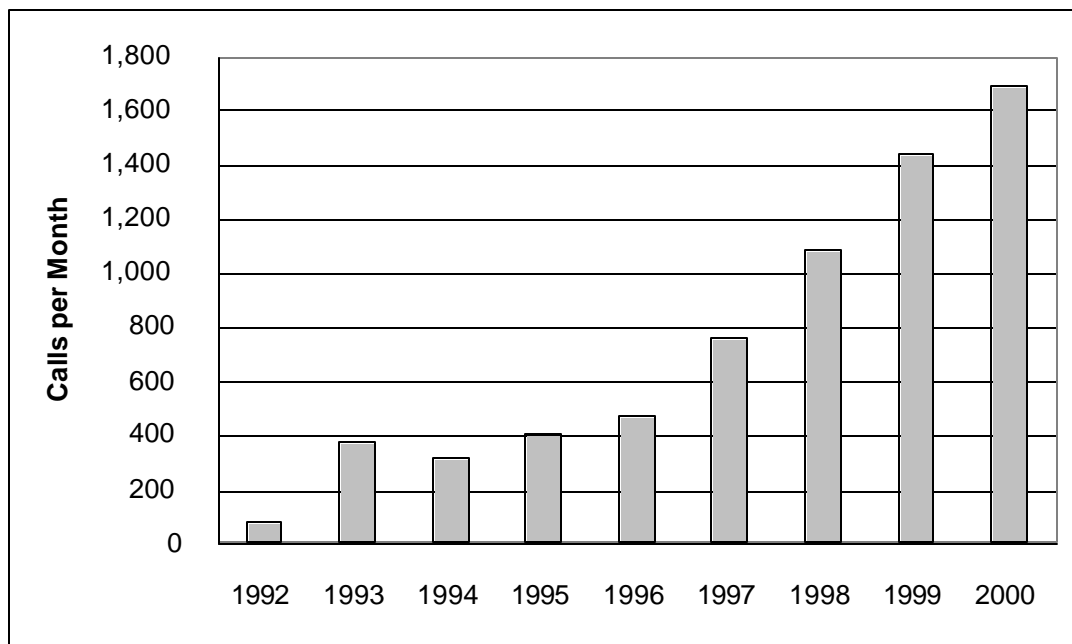
**Figure 12.** A Helpline-produced poster designed for distribution to schools and physicians’ offices to promote Helpline services



counseling themselves, but they can be encouraged to ask their patients whether they smoke and to refer those who do to the Helpline. With a little reinforcement of such efforts, many physicians across the state have become regular Helpline referral sources. Second, the outreach group sends promotional packets to all high school tobacco educators, and strives to build links with school personnel who are working around the state in youth tobacco use prevention and control. Figure 12 shows a poster that was developed for this sort of a

mailing. Finally, the group sends Helpline newsletters to, and forges links with, all of the county-level and regional tobacco control bodies, local and statewide voluntary agencies, ethnic networks, and competitive grantees of the Tobacco Control Program. The success of these efforts—the Outreach team's efforts combined with those of many individuals and organizations around the state—are reflected in the fact that personal referrals have steadily and dramatically increased over the years, as shown in Figure 13.

**Figure 13.** Average monthly number of Helpline callers each year who reported that they were referred by non-media sources—e.g., medical providers, voluntary agencies, schools, friends and family members, etc. (Note: data for 1992 includes August through December only; data for 2000 includes January through March).





## OPERATIONAL STRUCTURE

### Funding

Funding for the Helpline has several sources, but chief among them is the California Department of Health Services (DHS), Tobacco Control Section (TCS). Monies awarded by TCS are the result of Proposition 99, the voter-approved initiative of 1988 that levied a tax of 25 cents on each pack of cigarettes sold in California, a portion of which supports the Tobacco Control Program.

TCS awards are the financial mainstay of the Helpline, making possible the greater part of its service activities and a substantial portion of its cessation research as well. Also providing funds for research are the Tobacco Related Diseases Research Program (a Prop. 99-funded entity administered by the University of California) and the National Institutes of Health. All mass media advertising of the Helpline is funded directly by TCS.

### Helpline Management

The Helpline is operated by the Cancer Prevention and Control unit of the University of California, San Diego Cancer Center. It is headed by a researcher and faculty member of the UCSD School of Medicine who serves as principal investigator (PI). The fact that the

Helpline's leading position is occupied by a researcher is reflected in the program's emphasis on developing innovative behavioral interventions and subjecting them to rigorous testing.

Management of the Helpline is divided into three broad areas, each of which is headed by a full-time manager who reports to the PI, as illustrated in Figure 14. An operations director oversees all administrative functions, including human and physical resources, contract and budget issues, and overall program performance. A California-licensed psychologist serves as clinical director, ensuring the psychological soundness of the Helpline's counseling interventions and compliance with ethical and legal issues pertaining to counseling, and providing training and clinical supervision for

staff. Finally, a research manager coordinates the program's investigational activities, assisting the PI in the design and implementation of studies.

A third tier of management provides direct supervision for "front-line" staff members, who are divided by function into several project components.

## Outreach

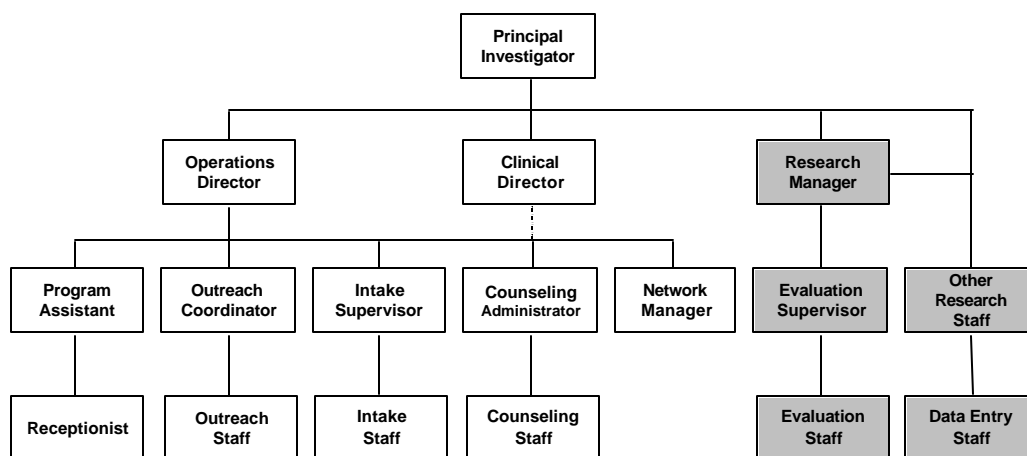
The first of these components, in order of clients' progress through the program, is Outreach. The Helpline's outreach efforts are led by a Master of Public Health with a background in social marketing and tobacco control. The outreach coordinator reports to the operations director, and is aided by two full

time counselors who, beside their duties in Outreach, also maintain a counseling caseload. This component of the program (described more fully in the section detailing promotion), has the mission of building awareness of the Helpline's services among professionals who interact with tobacco users and encouraging referral to the program.

## Intake

The second component of the program is Intake. The intake supervisor, who reports to the operations director, oversees a staff of about 25 part time "screeners" who are all undergraduate students at UCSD. Callers' first contact with the program is usually with someone in this department. Almost all screeners speak at least two of the Helpline's

**Figure 14.** Organizational structure of the California Smokers' Helpline





six languages—English, Spanish, Korean, Vietnamese, Mandarin, and Cantonese. With each new caller, the screeners administer a four-minute intake survey in the appropriate language. They gather personal, behavioral, and demographic information, explain how the program operates, offer a choice of services, and screen for eligibility to participate in Helpline research studies. They enter intake data into a master database, and assemble and mail individualized quitting materials to each caller. Their work hours are distributed across a 64-hour workweek to ensure maximum coverage in each language.

## Counseling

The third and largest program component is Counseling. A full time counseling administrator, who reports to the operations director, oversees a staff of about 35 counselors. Although this would seem to be a very heavy supervisory load, it is lightened somewhat by the fact that at the Helpline, clinical supervision is provided by the clinical director and two senior counselors. The clinical director and senior counselors provide training and continuing education on counseling issues, and ensure high clinical standards, while the counseling administrator is responsible for personnel issues, staffing and scheduling, distributing the counseling workload, and ensuring that performance goals are met. All counselors are university graduates and many either hold or are working toward advanced degrees in counseling, social work, or psychology. Some counselors are interns acquiring experience in behavior modification and addictions therapy and hours toward licensure. Their main duty is to provide intensive individual assistance to newly assigned clients to help them prepare to quit, and to previously assigned clients to help them avoid relapse.

They also provide certification of enrollment in counseling as needed, maintain accurate records of interactions with clients, and help with intake when the incoming call volume is high. Each counselor keeps the same hours throughout the week, but collectively their hours are distributed according to when clients request counseling: about 40% in the morning, 15% in the afternoon, and 45% in the evening.

## Evaluation

The fourth component of the program is Evaluation. An evaluation supervisor, who reports to the research manager, oversees the work of about ten evaluators, most of whom are part-time undergraduate students. The evaluators call research subjects and randomly selected Helpline participants after they have received service and administer in-depth satisfaction and behavioral assessments. They then enter the information into the master database for analysis of outcomes.

## Other Research Personnel and Support Staff

Other research staff members perform statistical analysis, programming, and data management, and assist with survey and experimental design, implementation of studies, coding of data, and analysis and publication of results. They report variously to the research manager, the senior statistician, and the PI. In Figure 14, the research branch of the Helpline is shaded to indicate that the positions in this part of the program may be considered separately from the service components. Helpline staff also includes a full time network administrator and personnel who provide administrative and clerical assistance.



## PHYSICAL REQUIREMENTS

Space requirements for a program such as the California Smokers' Helpline are modest compared to those of comparable cessation programs which provide service in-person and on-site. The Helpline is located in a suite of offices in La Jolla, near the University of California, San Diego, among other medical, research, and academic facilities. Because there is little outside business traffic and no client traffic, and because the Helpline employs many part time staff working different shifts, the program can be accommodated in a fairly compact space. Counselors are provided with individual cubicle workstations.

### **The Network and Database**

All Helpline workstations are linked in a local area network (LAN), with shared resources on a central server. Chief among these is the Helpline's master database of client information. The database allows multiple staff to enter, check, query, and analyze data about the same clients. It allows the Helpline to track its interactions with clients and the progress they make as they move through the program. The date, time, and length of every interaction are recorded, as well as other pertinent data depending on the type of call. The database

enables the program to organize client appointments and run queries to ensure that all clients are accounted for. It enables quality control over important service variables such as the length of time between requesting and receiving counseling, and the average number of counseling sessions provided per client. It allows the Helpline to set quantifiable service goals and to measure its performance with respect to those goals. In combination with a statistical analysis package, it allows the Helpline to analyze outcome data and contribute to the field of cessation research.

Another network feature of which the Helpline takes full advantage is its capacity for facilitating communication among staff. Like most organizations, the Helpline uses email for communicating across shifts and departments, but it has also developed an intranet site for staff. The site is equivalent to a navigable web site but only accessible within the LAN. It includes the complete training manuals for intake, counseling, and evaluation, updated versions of all protocols currently in use, referral lists, crisis information, recent developments in tobacco control, news from ongoing Helpline research projects, important office memos, updates to the organizational chart, a staff directory, and other information. Besides cutting down on paper waste, the site ensures that all staff have fingertip access to the most important and up-to-date information.

## Telephony

### *Lines and Hardware*

A large telephone-based program such as the California Smokers' Helpline requires a sophisticated telephone system, starting with toll-free access. While not expensive in themselves, desirable toll-free telephone numbers can be difficult to obtain. The Helpline is fortunate to have acquired 1-800-NO-BUTTS, which is both meaningful and easy to remember, for its main English line, and 1-800-45-NO-FUME, which also is meaningful ("Don't smoke")—if somewhat less easy to remember—for its main Spanish line. The Helpline has separate toll-free lines for each of the languages in which it offers service, as well as a TDD line for the hearing impaired, an English line for smokeless tobacco users, message lines for the use of clients who are already

working with a particular counselor, and others.

By using T1 lines as opposed to conventional switched-access lines, the Helpline is able to secure very low rates on its long-distance calls, both toll-free incoming calls from clients and outbound calls by staff. T1 lines are more efficient and cheaper to use than conventional lines because they allow for greater compression of the signal, and thus fuller use of channels.

### *Automatic Call Distribution and Voicemail*

Like its computer system, the Helpline's telephone system is internally networked and tied to a central server. An important feature made possible by this arrangement is automatic call distribution (ACD). The skills of each staff member (i.e., languages spoken and protocols trained upon) are entered into the phone server, and each staff member is assigned a unique password to log into the system. Then as calls come in over the various toll-free lines, the ACD distributes them among the staff who are logged in at that moment, wherever they are in the office. ACD can also be used to organize staff into groups. At the Helpline, as already mentioned, the intake department handles most of the incoming calls. ACD preferentially routes such calls to screeners. However, if call volume peaks and the ACD determines that clients are on hold too long, it can route the excess calls to counselors.

ACD can be programmed to include user-defined priorities. Calls can always be routed first to a certain staff member, or they can be routed to whoever has not handled a call in the

longest amount of time. The lines themselves can also be assigned priorities. For example, since the Helpline has fewer Korean-speaking staff than English-speaking staff, the Korean line is assigned a higher priority. This causes the less-frequent Korean calls to be routed straight to the first available bilingual Korean/English staff member ahead of the more-frequent English calls, which can easily be routed to other English-speaking staff members. In this way, ACD helps redress imbalances caused by differences in the levels of staffing for the various languages and ensures that all callers are served promptly.

ACD also allows the Helpline to determine what the caller will hear if he or she is waiting in queue. Announcements are timed in such a way as to keep callers engaged, and soothing music is played in the intervals. If a staff member does not answer promptly, the caller is given the option of exiting the queue and leaving a voicemail message to be called back. Also, the system plays different announcements at different times of the day and week. For example, clients calling during heavy call volume are asked to hold for the next available agent, while those calling after hours are asked to leave a message and are then routed straight to voicemail.

Finally, ACD allows for easy monitoring of the toll-free lines. The intake supervisor views a computer screen with real-time displays of everything that is happening on the system. It shows who is logged in, how many calls are in queue for each line, how long the longest caller has been waiting, etc. It also provides useful summary statistics on the Helpline's recent performance with respect to such calls.

The Helpline's telephone system includes on-site voicemail, so the Helpline does not need external voicemail either for its toll-free lines or for its business lines. Consequently it enjoys savings from not having to pay for off-site voicemail services such as local telephone companies offer on a cost-per-box basis.

### *Interfacing the Phones and Computers*

A final important feature of the Helpline's telephone system is the incorporation of Computer Telephony Integration (CTI), which is currently being tested. This technology allows the telephones and computers to share data. The computer can upload data from the telephone, such as line used and date, time, and length of call. For outgoing calls, it can download telephone numbers from the database so they do not have to be manually dialed. In both ways, CTI increases efficiency.

## 12 SUGGESTIONS FOR REPLICATION

The California Smokers' Helpline is a pioneer in the provision of telephone-based cessation services, but it is not the only model for organizations interested in joining the field. Though they share the mission of helping individuals quit using tobacco, helplines around the world vary widely in how they approach that challenge.

In the Netherlands, Stivoro, the Dutch Foundation on Smoking and Health, developed a menu of auto-attendant recordings to give user-defined help on an efficient, low-cost basis. In England, an exceptionally well-utilized service called Quit offers packets of materials and brief counseling on a hotline basis. The Quit Victoria Smoking and Health Program in Australia provides both pre-quit and some follow-up counseling. The California program, with its extended protocol of pre-quit and follow-up counseling, offers a comparatively intensive intervention, relative to other international helpline activity. But with respect to the number of clients served, the Helpline falls somewhere in the middle of a wide range. To give an idea of just how wide that range is, a start-up helpline in Ireland operated by the Irish Cancer Society recently reported 600 callers in its first year. The more established California program may seem like a giant in comparison, with about 32,000 calls during the same time period time, until it in

turn is compared with the English program, which fielded about half a million calls. Clearly, an organization planning to begin providing telephone-based cessation services has some important decisions to make about the intensity and breadth of services it will offer.

Those who follow the California model may want to consider a few suggestions. First, the content and timing of the Helpline's counseling protocol appear to be crucial factors contributing to its effectiveness. Researchers have studied several telephone counseling protocols that achieved no effect, so success is by no means assured. New helplines should strongly consider using a proven protocol. Or, if they plan to develop their own, they should give as much thought and attention to this part of the operation as to any other, starting with a thorough review of the scientific literature on effective telephone counseling interventions.

A related suggestion is to be wary of imitating innovative new protocols that are still in the process of being experimentally tested. For example, several states have indicated eagerness to adopt the Helpline's approach to working with teens, even though no organization, including the Helpline, has yet published results demonstrating an effective intervention for teen cessation. For that reason, the Helpline has so far declined to allow others to implement its teen protocol.

A more logistical suggestion is that a new helpline does not have to start up all of the services it plans to offer at the same time. For example, it would be possible to start by offering mailed materials and referral only, then add counseling for adult smokers, then counseling for adolescents, and so on. Service for smokers who speak languages other than English could likewise be phased in after the English line is up and running. And, it will streamline start-up if the organization implementing the new helpline project already has the appropriate telephone infrastructure and experience operating a telephone-based service.

Currently in the Helpline's development, its organizational structure includes many positions that are fairly specialized, but this was not always the case. A new program starting small may need or wish to combine functions that the Helpline has found convenient to separate. For example, clinical supervision and administrative oversight could both be handled by one licensed professional with a talent for administration. Likewise, network administration and programming could both be handled by the same person. Most importantly, intake and counseling can be combined (as they were in the Helpline's first year).

Finally, not all organizations have a mandate or sufficient funding to conduct research, and duplication of the Helpline's service components alone without the research component is certainly possible. However, a portion of funding should still be earmarked for evaluation to ensure the efficacy of the replicated service in the new setting. And, to the extent possible, the staff conducting the evaluation surveys should be separate from those who provide the service, in order to avoid a conflict of interest that could skew the evaluation results.

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## CONCLUSION

Faced with the challenge of achieving large and lasting reductions in tobacco use, California adopted the innovative strategy of targeting the whole population for its anti-tobacco message, not just current users. This has had the desired effect of creating an environment in which tobacco use has become a much less accepted practice.

This in turn makes tobacco users want to quit. Many of them simply quit on their own, which from the standpoint of maximizing public health resources is a very attractive way to accomplish cessation. However, a subset of them may want to quit very badly but require assistance to do so. What is needed is a way to provide real help to these people, wherever they are in the state.

The Helpline is well suited to fill this need. Its services have been proven effective and are accessible to people everywhere in the state, in several different languages. Because it is telephone-based, it can be operated from a single site, which makes it both easy to promote and easy to manage. It gives public health officials everywhere the confidence of having a place to refer the people in their communities who need help to quit. Yet despite its near-universal coverage, it requires a relatively small portion of the overall budget for tobacco control in California, leaving the bulk of the funding for the more global effort to achieve durable reductions in prevalence by

changing norms across the whole population.

The Helpline takes its role as the sole state-wide provider of cessation services seriously. Every effort is made to ensure the continued efficacy of existing interventions, and to develop new interventions that are demonstrably efficacious for under-served groups, such as teens and pregnant smokers. It coordinates with other components of the state's tobacco control program by promoting itself as a referral resource for others in the field who cannot themselves provide cessation services, by disseminating up-to-date information about other cessation resources, and in general by supporting the normalization of quitting.

Like their counterparts in California, public health officials in other states or countries who must decide how to allocate precious tobacco control resources may find themselves weighing the provision of cessation services against other important goals. It may be tempting to focus solely on cessation, or solely on some

other goal, such as reducing exposure to secondhand smoke, countering pro-tobacco influences, preventing youth access to tobacco, or reducing youth uptake. But the success of the California program seems to argue for a more comprehensive approach in which the problem of tobacco use is attacked on several

fronts and in which the provision of cessation services plays an important role. At whatever level other states or countries may decide to budget for cessation services, they are strongly encouraged to include a telephone-based service such as the California Smokers' Helpline.



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